		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035204

Facility Name: Rosewood Care Center of East Peoria

Address: 900 Centennial Drive (Number) East Peoria (City) 61611 (Zip Code)

County: Tazewell

Telephone Number: (309) 699-5400 **Fax #** ( )

IDPA ID Number: 431446788001

Date of Initial License for Current Owners: 04/18/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: : Cindy A. Tefteller **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2000 to 06/30/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountant's Compilation Report (Date)
(Print Name and Title) Cindy A. Tefteller
(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 East Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			7,329	7,329	8
9	SNF/PED					9
10	ICF	10,434	14,424		24,858	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,434	14,424	7,329	32,187	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.49%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/19/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/19/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 38 and days of care provided 7,329

Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2001 Fiscal Year: 06/30/2001

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 **Report Period Beginning:** 07/01/2000 **Ending:** 06/30/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	179,120	15,509	7,416	202,045		202,045		202,045			1
2	Food Purchase		149,164		149,164		149,164	(9,363)	139,801			2
3	Housekeeping	111,628	22,330		133,958		133,958		133,958			3
4	Laundry	39,729	12,214		51,943		51,943		51,943			4
5	Heat and Other Utilities			109,837	109,837		109,837	184	110,021			5
6	Maintenance	26,538	11,765	70,112	108,415		108,415	16,802	125,217			6
7	Other (specify):* Sanitation			18,428	18,428		18,428		18,428			7
8	**TOTAL General Services**	357,015	210,982	205,793	773,790		773,790	7,623	781,413			8
	B. Health Care and Programs											
9	Medical Director			2,062	2,062		2,062		2,062			9
10	Nursing and Medical Records	1,451,145	129,226	222,397	1,802,768		1,802,768		1,802,768			10
10a	Therapy	75,793	3,721	410,850	490,364		490,364	(7,437)	482,927			10a
11	Activities	43,922	3,561	2,202	49,685		49,685		49,685			11
12	Social Services	50,452		2,225	52,677		52,677		52,677			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,621,312	136,508	639,736	2,397,556		2,397,556	(7,437)	2,390,119			16
	C. General Administration											
17	Administrative			396,636	396,636		396,636	(269,081)	127,555			17
18	Directors Fees											18
19	Professional Services			4,238	4,238		4,238	35,622	39,860			19
20	Dues, Fees, Subscriptions & Promotions			20,774	20,774		20,774	(6,635)	14,139			20
21	Clerical & General Office Expenses	127,307	24,048	20,604	171,959		171,959	121,585	293,544			21
22	Employee Benefits & Payroll Taxes			280,546	280,546		280,546	27,529	308,075			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,198	1,198		1,198	(17)	1,181			24
25	Other Admin. Staff Transportation			8,262	8,262		8,262	13,853	22,115			25
26	Insurance-Prop.Liab.Malpractice			34,379	34,379		34,379	4,137	38,516			26
27	Other (specify):*											27
28	**TOTAL General Administration**	127,307	24,048	766,637	917,992		917,992	(73,007)	844,985			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,105,634	371,538	1,612,166	4,089,338		4,089,338	(72,821)	4,016,517			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rosewood Care Center of East Peoria #0035204 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			12,800	12,800		12,800	166,438	179,238			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			76,642	76,642		76,642	279,016	355,658			32
33	Real Estate Taxes			59,596	59,596		59,596		59,596			33
34	Rent-Facility & Grounds			614,093	614,093		614,093	(602,927)	11,166			34
35	Rent-Equipment & Vehicles			7,322	7,322		7,322		7,322			35
36	Other (specify):*											36
37	TOTAL Ownership			770,453	770,453		770,453	(157,473)	612,980			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		126,062	15,055	141,117		141,117	(1,057)	140,060			39
40	Barber and Beauty Shops			18,835	18,835		18,835		18,835			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		126,062	99,590	225,652		225,652	(1,057)	224,595			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,105,634	497,600	2,482,209	5,085,443		5,085,443	(231,351)	4,854,092			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,032)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(12,682)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,057)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(331)	2		13
14	Non-Care Related Interest	(76,642)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment	(17)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,314)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,978)	20		28
29	Other-Attach Schedule Marketing Salary	(54,958)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (162,011)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(69,340)	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (69,340)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (231,351)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Rosewood Care Center of East Peoria

ID# 0035204

Report Period Beginning: 07/01/2000

Ending: 06/30/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (54,958)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(54,958)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,363)	0	0	0	0	0	0	0	0	0	0	(9,363)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	184	0	0	0	0	0	0	0	0	184	5
6	Maintenance	0	0	16,802	0	0	0	0	0	0	0	0	16,802	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,363)	0	16,986	0	0	0	0	0	0	0	0	7,623	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(7,437)	0	0	0	0	0	0	0	0	0	(7,437)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(7,437)	0	0	0	0	0	0	0	0	0	(7,437)	16
	C. General Administration													
17	Administrative	0	(376,636)	107,555	0	0	0	0	0	0	0	0	(269,081)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,756	31,866	0	0	0	0	0	0	0	0	35,622	19
20	Fees, Subscriptions & Promotions	(7,292)	0	657	0	0	0	0	0	0	0	0	(6,635)	20
21	Clerical & General Office Expenses	(54,958)	100	176,443	0	0	0	0	0	0	0	0	121,585	21
22	Employee Benefits & Payroll Taxes	0	290	27,239	0	0	0	0	0	0	0	0	27,529	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(17)	0	0	0	0	0	0	0	0	0	0	(17)	24
25	Other Admin. Staff Transportation	0	0	13,853	0	0	0	0	0	0	0	0	13,853	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,137	0	0	0	0	0	0	0	0	4,137	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(62,267)	(372,490)	361,750	0	0	0	0	0	0	0	0	(73,007)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(71,630)	(379,927)	378,736	0	0	0	0	0	0	0	0	(72,821)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Rosewood Care Center of East Peoria** **#** **0035204** **Report Period Beginning:** **07/01/2000** **Ending:** **06/30/2001**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	144,902	21,536	0	0	0	0	0	0	0	0	166,438	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(89,324)	368,340	0	0	0	0	0	0	0	0	0	279,016	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(614,093)	11,166	0	0	0	0	0	0	0	0	(602,927)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(89,324)	(100,851)	32,702	0	0	0	0	0	0	0	0	(157,473)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(1,057)	0	0	0	0	0	0	0	0	0	0	(1,057)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(1,057)	0	0	0	0	0	0	0	0	0	0	(1,057)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(162,011)	(480,778)	411,438	0	0	0	0	0	0	0	0	(231,351)	45

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Larry Vander Maten	75.00%	See Attached List		See Attached List		
Darrell Hoefling	25.00%	See Attached List		See Attached List		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fee	$ 396,636	HSM Management	100.00%	$	$ (396,636)	1
2	V								2
3	V	10a	Therapy	410,850	Rosewood Therapy Services, Inc.	0.00%	403,413	(7,437)	3
4	V								4
5	V	34	Rent	614,093	East Peoria Real Estate, Inc.	0.00%		(614,093)	5
6	V	30	Depreciation		East Peoria Real Estate, Inc.		144,902	144,902	6
7	V	32	Interest		East Peoria Real Estate, Inc.		368,340	368,340	7
8	V	19	Professional Fees		East Peoria Real Estate, Inc.		3,756	3,756	8
9	V	17	Owners Compensation		East Peoria Real Estate, Inc.		20,000	20,000	9
10	V	22	Payroll Taxes		East Peoria Real Estate, Inc.		290	290	10
11	V	21	Office Expense		East Peoria Real Estate, Inc.		100	100	11
12	V								12
13	V								13
14	Total			$ 1,421,579			$ 940,801	$ * (480,778)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	See Schedule VIII	$	HSM Management Services, Inc.	100.00%	$ 107,555	$ 107,555	15
16	V	21	See Schedule VIII		HSM Management Services, Inc.	100.00%	176,443	176,443	16
17	V	22	See Schedule VIII		HSM Management Services, Inc.	100.00%	27,239	27,239	17
18	V	25	See Schedule VIII		HSM Management Services, Inc.	100.00%	13,853	13,853	18
19	V	30	See Schedule VIII		HSM Management Services, Inc.	100.00%	21,536	21,536	19
20	V	34	See Schedule VIII		HSM Management Services, Inc.	100.00%	11,166	11,166	20
21	V	19	See Schedule VIII		HSM Management Services, Inc.	100.00%	31,866	31,866	21
22	V	26	See Schedule VIII		HSM Management Services, Inc.	100.00%	4,137	4,137	22
23	V	6	See Schedule VIII		HSM Management Services, Inc.	100.00%	16,802	16,802	23
24	V	5	See Schedule VIII		HSM Management Services, Inc.	100.00%	184	184	24
25	V	20	See Schedule VIII		HSM Management Services, Inc.	100.00%	657	657	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 411,438	$ * 411,438	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Larry Vander Maten	President	Management	75.00%	724,357	3	5.59%	Salary	$ 53,136	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	218,119	3	5.59%	Salary	14,378	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 67,514		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 07/01/2000 Ending: 6/30/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HSM Management Services, Inc.
Street Address: 11701 Borman Drive, Suite 315
City / State / Zip Code: St. Louis, MO 63146
Phone Number: (314) 994-9070
Fax Number: (314) 994-9912

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries-Officers	Total Cost	75,137,033	17	$ 849,990	$ 849,990	4,200,086	$ 47,514	1
2	21	Salaries-Others	Total Cost	75,137,033	17	2,658,369	2,658,369	4,200,086	148,600	2
3	22	Payroll Taxes	Total Cost	75,137,033	17	282,151		4,200,086	15,772	3
4	22	Employee Benefits	Total Cost	75,137,033	17	140,469		4,200,086	7,852	4
5	25	Travel	Total Cost	75,137,033	17	180,072		4,200,086	10,066	5
6	30	Depreciation	Total Cost	75,137,033	17	351,550		4,200,086	19,651	6
7	34	Building Rent	Total Cost	75,137,033	17	199,753		4,200,086	11,166	7
8	19	Professional Services	Total Cost	75,137,033	17	570,072		4,200,086	31,866	8
9	21	Telephone	Total Cost	75,137,033	17	200,687		4,200,086	11,218	9
10	26	Insurance	Total Cost	75,137,033	17	74,012		4,200,086	4,137	10
11	21	Taxes & Licenses	Total Cost	75,137,033	17	11,527		4,200,086	644	11
12	21	Office Supplies	Total Cost	75,137,033	17	285,895		4,200,086	15,981	12
13	6	Maintenance	Total Cost	75,137,033	17	300,583		4,200,086	16,802	13
14	5	Heat & Other Utilities	Total Cost	75,137,033	17	3,293		4,200,086	184	14
15	20	Dues & Subscriptions	Total Cost	75,137,033	17	11,759		4,200,086	657	15
16	17	Direct - Admin	Direct Cost	1	1	60,041	60,041	1	60,041	16
17	17	Direct - Admin	Direct Cost	16	16	854,853	854,853	0	0	17
18	22	Direct - Payroll Taxes	Direct Cost	1	1	3,615		1	3,615	18
19	22	Direct - Payroll Taxes	Direct Cost	16	16	51,803		0	0	19
20	30	Direct - Depreciation	Direct Cost	1	1	1,885		1	1,885	20
21	30	Direct - Depreciation	Direct Cost	16	16	25,803		0	0	21
22	25	Direct - Travel	Direct Cost	1	1	3,787		1	3,787	22
23	25	Direct - Travel	Direct Cost	16	16	135,415		0	0	23
24										24
25	TOTALS					$ 7,257,384	$ 4,423,253		$ 411,438	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank of America		X	Refinance Bonds	$35,233.00	10/26/99	$ 4,027,366	$ 3,961,228	11/2009	8.89%	$ 378,622	1
2	Less: Interest Income Offset										(12,682)	2
3	Less: Related Party Interest Income Offset										(10,282)	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$35,233.00		$ 4,027,366	$ 3,961,228			$ 355,658	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,027,366	$ 3,961,228			$ 355,658	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 **Report Period Beginning:** 07/01/2000 **Ending:** 06/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	63,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	61,496	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,704)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	61,300	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	59,596	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	59,292	8
	1997	62,971	9
	1998	69,551	10
	1999	61,719	11
	2000	61,273	12

1999 Payment $ 30,860

2000 Payment $30,636

Accrual = Remaining 2000 Tax Bill (30,600) +1/2 estimated 2001 tax bill (30,700)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center of East Peoria COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0035204

CONTACT PERSON REGARDING THIS REPORT Lou Netemeyer

TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	01-01-24-100-010	Sec 24 T26N R4W	$ 61,272.96	$ 61,272.96
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 61,272.96	$ 61,272.96

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,125 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	7.68 Acres	1988	$ 85,906	1
2					2
3	TOTALS			$ 85,906	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1989	$ 2,953,579	$	10-25	$ 123,806	$ 123,806	$ 1,649,324	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements - Original Construction			1989	209,624		15-25	10,276	10,276	125,882	9
10	Fence			1990	2,377		25	95	95	950	10
11	Concrete Work			1991	5,190		25	208	208	2,080	11
12	Painting			1992	7,694		5			7,694	12
13	Irrigation System			1993	10,175		25	407	407	3,290	13
14	Generator			1989	14,937		10			14,937	14
15	Signs			1989	3,157		10			3,157	15
16	Walk-In Cooler			1989	5,770		20	289	289	3,540	16
17	Sinks			1989	3,744		10			3,744	17
18	Exhaust Hood			1989	4,621		10			4,621	18
19	Fire System			1989	1,271		20	64	64	784	19
20	Carpeting			1989	10,368		10			10,368	20
21	Cubicle Track			1989	6,294		10			6,294	21
22	Door Installation			1991	2,750		10	275	275	2,681	22
23	Sprinkler Addition			1992	786		10	79	79	751	23
24	Ceramic Sink			1994	2,011		10	201	201	1,340	24
25											25
26	Leasehold Improvements - Facility:										26
27	Carpeting			1994	3,238	344	7	344		3,238	27
28	Painting, Baseboard Stripping, Drapery, Tile, Carpet			1995	37,083	5,297	7	5,297		33,590	28
29	Painting			1996	3,960	565	7	565		2,765	29
30	Wallpaper			1998	3,525	504	7	504		1,638	30
31	Floor Covering/Wallpaper/Plants			1998	18,546	2,649	7	2,649		7,097	31
32	Mini Blinds/Wallcovering			1999	5,486	784	7	784		1,774	32
33	Carpeting			1999	4,375	625	7	625		1,146	33
34	Computer Cabling			2000	2,392	200	7	200		200	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Computer Receptacles	2001	$ 214	$ 16	7	$ 16	$	$ 16	37
38	Doors	2001	5,966	213	7	213		213	38
39	Parking Lot	2001	11,475	273	7	273		273	39
40									40
41	Leasehold Improvements - Management Company:								41
42	Office Construction / Improvements	1995	428		5			428	42
43	Office Design	1995	39		5			39	43
44	Office Shelving	1996	91		4			91	44
45	Office Expansion	1996	404		4			404	45
46	Office Expansion	1997	1,082		3			1,082	46
47	Office Expansion	1998	610		3	203	203	565	47
48	Office Addition	1999	301		3	100	100	201	48
49	Door Locks	1999	151		3	51	51	79	49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,343,714	$ 11,470		$ 147,524	$ 136,054	$ 1,896,276	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 156,920	$	$ 19,326	$ 19,326	5-7 Yrs	$ 85,772	71
72	Current Year Purchases	37,032	1,330	3,756	2,426		3,756	72
73	Fully Depreciated Assets	390,376					390,376	73
74								74
75	TOTALS	$ 584,328	$ 1,330	$ 23,082	$ 21,752		$ 479,904	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSM Management	Various	Various	$ 33,791	$	$ 8,632	$ 8,632	4 Yrs	$ 20,243	76
77										77
78										78
79										79
80	TOTALS			$ 33,791	$	$ 8,632	$ 8,632		$ 20,243	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,047,739	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 12,800	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 179,238	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 166,438	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,396,423	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Schedule Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

N/A - ONLY HIRE CERTIFIED AIDES
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-8	hrs	$	24,129	$ 193,091	$	24,129	$ 193,091	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		2,480	4,920		2,480	4,920	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		41,199	205,402	3,721	41,199	209,123	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				97,331		97,331	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Laboratory, X-Ray, Enterals Other (specify): & Specialty Beds	39-8				13,998	28,731		42,729	13
14	TOTAL			$	67,808	$ 417,411	$ 129,783	67,808	$ 547,194	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 200,821	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 44,000)	1,020,017		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,336		6
7	Other Prepaid Expenses	2,770		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Def Inc Tax Benefit	14,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,250,944	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	105,572		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(53,280)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 52,292	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,303,236	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 238,070	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	762,000		29
30	Accrued Salaries Payable	191,279		30
31	Accrued Taxes Payable (excluding real estate taxes)	34,336		31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,300		32
33	Accrued Interest Payable	35,897		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	114,836		36
37	Accrued Rent	61,500		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,499,218	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,499,218	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (195,982)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,303,236	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (251,181)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (251,181)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	55,199	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 55,199	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (195,982)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,171,710	1
2	Discounts and Allowances for all Levels	(1,648,203)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,523,507	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,603,281	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,603,281	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	24,247	13
14	Non-Patient Meals	9,032	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 33,279	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14,026	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,026	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Lab Discounts	1,057	28
28a	Miscellaneous Income	992	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,049	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,176,142	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	773,790	31
32	Health Care	2,397,556	32
33	General Administration	917,992	33
	B. Capital Expense		
34	Ownership	770,453	34
	C. Ancillary Expense		
35	Special Cost Centers	159,952	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,085,443	40
41	**Income before Income Taxes (line 30 minus line 40)****	90,699	41
42	**Income Taxes**	(35,500)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 55,199	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Yes **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,078	2,182	$ 56,018	$ 25.67	1
2	Assistant Director of Nursing	1,992	2,091	41,746	19.96	2
3	Registered Nurses	23,154	24,305	466,173	19.18	3
4	Licensed Practical Nurses	10,126	10,629	171,886	16.17	4
5	Nurse Aides & Orderlies	62,201	65,294	661,335	10.13	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,996	6,294	75,793	12.04	8
9	Activity Director					9
10	Activity Assistants	5,391	5,659	43,922	7.76	10
11	Social Service Workers	4,038	4,239	50,452	11.90	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,396	22,460	179,120	7.98	15
16	Dishwashers					16
17	Maintenance Workers	2,209	2,319	26,538	11.44	17
18	Housekeepers	12,545	13,169	111,628	8.48	18
19	Laundry	5,774	6,061	39,729	6.55	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,120	12,723	127,307	10.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,069	4,272	53,987	12.64	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	173,089	181,697	$ 2,105,634 *	$ 11.59	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	320	$ 7,416	1-3	35
36	Medical Director	Contract	2,062	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	120	2,202	11-3	44
45	Social Service Consultant	125	2,225	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	565	$ 13,905		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	6,352	107,984	10-3	51
52	Nurse Aides	12,713	114,413	10-3	52
53	TOTAL (lines 50 - 52)	19,065	$ 222,397		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
B. Chasteen	Administrator	0.00%	$ 60,041
Total Direct Administrator Cost from HSM Mgmt - Line 17, col 7			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 60,041

B. Administrative - Other

Description	Amount
Management Fees	$ 396,636
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 396,636

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company	Accountant/Consultant	$ 4,238
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 4,238

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 74,793
Unemployment Compensation Insurance	34,327
FICA Taxes	159,326
Employee Health Insurance	8,332
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Management Company Allocations	27,529
Employee Uniforms	721
Employee Relations	2,637
Employee Physicals	410
TOTAL (agree to Schedule V, line 22, col.8)	$ 308,075

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,370
Health Care Worker Background Check	
(Indicate # of checks performed 63)	889
Misc. Dues & Subscriptions	7,223
Promotional Advertising	4,292
Management Company Allocations	657
Less: Public Relations Expense	(650)
Non-allowable advertising	(664)
Yellow page advertising	(2,978)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,139

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,181
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,181

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Schedule Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria **#** 0035204 **Report Period Beginning:** 07/01/2000 **Ending:** 06/30/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **55,078** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,700**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **9,032**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **No facility specific audit report**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.